

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

	TIT PICA PICA													ΠŪ									
1. M														1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
(M	(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) BLK LUNG (ID#)																						
2. PAT	I MM I DD I YY — I													4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
Nir	Nirnoyy Nasidy 06 12 2017 M F																						
5. PAT	IENT'S	ADDRE	SS (No.	, Street)					6. PA	TIENT RE	ELATION	NSHIP T	OINSU	IRED	7. INSURED'S ADDR		o., Street)				\Box		
							Self Spouse Child Other X								88 red st #2								
CITY							STATE 8. RESERVED FOR NUCC USE								CITY STATE								
															ti					ti	_ ĕ		
ZIP CO	DDE			TEL	EPHON.	IE (Induc	be Area	Code)							ZIP CODE		TEL	EPHONI	E (Indude .	Area Code)	M		
				()	l									ti			()		<u> </u> ;		
9. OTH	IER INS	SURED'S	3 NAME	(Last Na	ame, Fir	st Name,	Middle	nitial)	10. IS	PATIENT	r's con	NOITION	RELAT	ED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER								
															5ui5oi								
a. OTHER INSURED'S POLICY OR GROUP NUMBER									a. ⊟M	IPLOYME	—		_	us)	a. INSURED'S DATE OF BIRTH SEX								
h DEG	SEDVE	FORN	ILICO LI	20					h 010	TO 1 000	YES	L	_ ио					IVI		F	_ ≌		
D. 1100		Z I OH N	.555 01						u. AU	TO ACCII	_	_	_	LACE (State)	b. OTHER CLAIM ID	(Desigr	nated by N	IUCC)			2		
0.000	EDVE	FORN	Heerin	RE .					C 07	L HER ACC	YES		Тио		6 INCLIDANCE DUAN	NIABAT	OP PDO	CDAMAN	LANGE		إ لا		
o. HES	en VEL	/ FOR N	000 08	JC					c. OH	HEM AUU	TYES	_	Пио		c. INSURANCE PLAN	NAME	: OH PHO	an AM N	(AIVIE		PATIENT AND INSURED INFORMATION		
d INC	LIBANO	E DL AN	NAME:	OR PRO	GRAMI	VAIME.			104.0	N AIRA ~				LICC)	d. IS THERE ANOTHI	50 UF 4	ALTH DEV	IECIT DI	AND		⊣ ₽		
u. INS	OHANG	e nuan	NAME	ON FRC	AMAIVI I	4₩ME			roa. C	CLAIM CC	v⊏8(E	esignate	eu by N	000)		1				On and Od	4		
			BE.	AD BAC	K OF FO	BM REE	OBE	OMPLETING	8 819	NING TH	ISFOR	M.			13. INSURED'S OR A	NO				9a, and 9d. BE Lauthorize	$\dashv \mid$		
			JTHORIZ	ZED PER	RSON'S	SIGNATI	URE La	uthorize the re	elease	of any me	edical or	other info			payment of medica	al benef							
	to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.													services described	i below.								
Signature on File													SIGNED Sigr	natur	e on F	ile			$ \downarrow $				
						r PREGN	IANCY (LMP) 15. C	OTHER	DATE					16. DATES PATIENT				URRENT (OCCUPATION	= ;		
06			ΥY	QUAL.				QUA	AL.		MN	N DE	1	YY	FROM D	D	YY	то		DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a.											18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES												
NASID KAMAL NIRNOY 17b.									NPI						FROM """	١.	- 11	TC					
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)															20. OUTSIDE LAB?			\$C	HARGES	'	\Box		
															YES	NO			0.0	00			
21. DI.	AGNO8	IS OR N	IATURE	OF ILLN	IESS OF	RINJURY	/ Relate	: A-L to servio	ce line	below (24	IE)	ICD Ind.			22. RESUBMISSION CODE		. ORK	GINAL B	EF. NO.		$\exists \bot$		
A. L	/125.5	500		B.	M25	.500	_	c. L				D.											
e. L			<u></u>	F.			_	g. L			_	H.			23. PRIOR AUTHORI	ZATION	NUMBE	R					
l. L					M25			к. L				L.									_ '		
24. A.	D/ From	ATE(S) C	OF SERY	/ICE To		B. PLACE OF	C.	D. PROCEI (Explain		3, SERVIO Sual Circu			IES	E. DIAGNOSIS	F.	G DAY	YS EPSDIT	I. ID.		J. RENDERING	N N		
ММ	DD	YY	MM	DD	YY	SERVICE	EMG	сет/ноес			MODI			POINTER	\$ CHARGES	UNIT	R Family TS Plan	QUAL		ROVIDER ID. #	⊣ ₹		
						1			- 1					1		1	- 1	L			≅		
06	12	17	06	12	17	24		72050							\$10.00			NPI	108388	7186	든		
		,_			<i>a</i> =				ı									L	400==	7400	SUPPLIER INFORMATION		
06	12	17	06	12	17	24		72070							\$10,00			NPI	108388	/186	- ≌		
00	10	17	00	40	47	24		70040	. 1					1	0000	1			108388	7400			
06	12	17	06	12	17	24		72040				<u>i</u>			\$0.00			NPI	100308	7 100			
06	12	17	06	12	17	24		72070							640.00			NPI	108388	7186			
00	14	''	00	12	17	4		12010						I	\$10.00	1		1951	100000	7 100			
06	12	17	06	12	17	24		72040							\$10.00			NPI	108388	7186			
55			33	_ · <u>-</u>		- "		, 2040							\$ 10.00				. 555500		PHYSICIAN OR		
06	12	17	06	12	17	24		72040							\$10.00			NPI	108388	7186	- ₹		
									S ACCOUNT NO. 27. ACCEPT ASSIGNMENT?						28. TOTAL CHARGE		29. AMC). Rsvd.for NUCC U	se		
$\overline{\mathbf{x}}$												YES		NO	See Pag	e 2	s Se	e Pa	ge 2				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. SERVICE FACILITY LOCA								LOCATIO	ON INFO	ORMATI	ON		33. BILLING PROVID	ER INF	O & PH#	()	-	$\exists 1$				
(i certify that the statements on the reverse								C DOUGLA						SADDLEBACK PORTABLE X-RAY									
ар	ply to th	is bill an	d are m	ade a pa	rt therec	of.)		1 N. BDI BL							P.O. BOX 4427	P.O. BOX 4427							
								JGLAS, AZ	8560	7					SANTA ANA, CA 9	2701							
SIGNED DATE								403	인	b.					a. 1083887186 b.								



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	EDICAR		MEDIC		TRIC	CARE		CHAMPVA	·	GROUP HEALTH	I PLAN	FE	CA K LUNG	OTHER	1a. INSURED'S	I.D. NUMBE	R		(For I	Program in Ite	em 1)		
(N	ledicare	#) X	(Medica	iid#)	(ID#)	(DoD#)		(Member ID		(ID#))#)	(ID#)									
				me, First	Name,	Middle In	nitial)			TENT'S E	BIRTH C	DATE YY_		BEX	4. INSURED'S	NAME (Last N	Name, Firs	t Name,	Middle	lnitial)			
		Nas		. Street)					06	- 1)17 №		F	7 INCUREDIO	*DDDE00 (*	le Obsert						
5. PA I	IENT'S	ADDRE	88 (No.	, Street)					6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other X						7. INSURED'S ADDRESS (No., Street)								
OITY								CTATE		<u></u>				Other X	88 red st #2								
CITY								SIAIE	8. HES	SERVED FOR NUCC USE					ti	ti	HE						
ZIP C	ODE			TEL	EPHON	JE (Indud	de Area	Code)							ZIP CODE		TEI	EPHON	E (Includ	de Area Code	0		
				17)			,							ti			1)	aa /	,,		
9. OTI	HER INS	SURED'S	3 NAME	(Last Na	me. Fir	st Name,	Middle	Initial)	10. IS I	PATIENT	'S CON	IDITION	RELAT	ED TO:	11. INSURED'S	POLICY GR	OUP OR F	ECA NU	JMBER				
				•				·							5ui5oi								
a. OTI	HER INS	SURED'S	POLIC	Y OR G	ROUP	IUMBER			a. EMF	PLOYME	NT? (CL	urrent or	Previou	us)	a. INSURED'S	DATE OF BIF	втн			SEX			
											YES	Г	NO		MM I	DD ,	ΥY	M		F			
b. RES	BERVED	FORN	ucc u	SE					b. AUT	TO ACCIE	DENT?		_ Р	LACE (State)	b. OTHER CLA	IM ID (Desig	nated by N	NUCC)					
											YES		NO	1 1									
c. RES	BERVED	FORN	UCC US	3E					c. OTH	HER ACC	IDENT	? _			c. INSURANCE	PLAN NAME	OR PRO	GR AM N	NAME				
											YES	[NO										
d. INS	URANC	E PLAN	NAME	OR PRO	GRAM	NAME			10d. C	LAIM CC	DES(D	esignate	ed by N	UCC)	d. IS THERE A	NOTHER HE	ALTH BEN	IEFIT PL	_AN?				
	_	_													YES	NO	If yes	, comple	ete items	9, 9a, and 9d	d.		
12. PA	TIENT'S	B OR AU	RE.	AD BACI ZED PER	K OF FO	ORM BEF	ORE C	OMPLETING outhorize the re	& SIGN elease o	NNG TH	IS FORM	vi. other inf	ormatio	n necessary	13. INSURED'S					TURE Lautho sician or supp			
to								enefits either t								cribed below		au aig	, iou pry	auror supp			
		Sians	ture	on Fi	le											Signatur	e on F	-ile					
										DATE													
			AL ILLIV		JURY, a !	r PREGN	NANCY	(LMP) 15. C QUA	OTHER VI	DATE !	MN	и Бі	9	YY	16. DATES PAT	TIENT UNABI	TE TO MC			IT OCCUPAT	TON		
06			BING P	QUAL. BOVIDE	BOBO	THER S	OUBCE	17a.	,,,,						FROM 18 HOSPITALI	ZATION DAT	ES BELAT	TO TED TO		NT SERVICE	S		
17.197				AL NII			DOTTOL	17a. 17b.	++						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM								
19. AE						ignated b	y NUCC		ı NPI						20. OUTSIDE LAB? \$CHARGES								
						_										YES NO 0.00							
21. DI	AGNO8	IS OR N	ATURE	OF ILLN	IESS O	R INJUR	Y Relate	e A-Litoservio	ce line below (24E) ICD Ind.						22. RESUBMISSION								
Δ I N	И 2 5.5	500		ь	M25	5.500		c I				D.	j l		CODE		ORIG	GINAL R	REF. NO.				
E.L				Б. Е			_	G. L	— и						23. PRIOR AUTHORIZATION NUMBER								
i. L				J.	M25	5.500		к. Ц				L.											
24. A		ATE(S) C	F SER			B. PLACE OF	C.	D. PROŒ					JES	E.	F.	G DA	YS IEPSD1	I.		J.	NO		
ММ	From DD	YY	MM	To DD	YY	SERVICE	EMG	CPT/HCP(ual Circui	MODI			DIAGNOSIS POINTER	\$ CHARGE	_ l o	R Family	ID. QUAL		RENDERI PROVIDER			
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06	12	17	06	12	17	24		72050							\$0	.00		NPI	1083	887186			
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25. FE	DERAL	TAX I.E	. NUME	i <u> </u>	1 <u> </u>	I EIN	26.	PATIENT'S A	CCOUN	NT NO.	27	LACCE	PT, ASS	BIGNMENT? see back)	28. TOTAL CH	: <u> </u>	29. AMC		AID I	30. Rsvd.for	NUCC Use		
	_					×						YES		see back) NO	\$	60.00	\$		0.00				
31. SI	GNATU	RE OF F	HYSICI	AN OR 8	<u> </u>		32.	BERVICE FA	CILITY	LOCATIO	ON INFO			1	33. BILLING PF				1		-		
INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse ASPC DOUGLAS																SADDLEBACK PORTABLE X-RAY							
				ade a pa			691	1 N. BDI BL	VD						P.O. BOX 4427								
							DO	UGLAS, AZ	85607						SANTA ANA	SANTA ANA, CA 92701							
SIGNED DATE a. 4403 NF										b.							b.						
SIGNE	±D				DATE		٠ ١	T-TUU							a. 10838 <mark>87186 b.</mark>								